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HOSPICE AND PALLIATIVE CARE WORKLOAD CAPTURE

1. PURPOSE: This Veterans Health Administration (VHA) Directive defines VHA responsibility in providing Hospice and Palliative Care (HPC) and VHA Policy on coding for HPC. Guidance is provided for ensuring consistent coding and facilitating accurate tracking of HPC workload in all settings to fulfill mandates of Public Law 106-117, the Veterans Millennium Health Care and Benefits Act of 1999.

2. BACKGROUND

a. The Veterans' Health Care Eligibility Reform Act of 1996 (Title 38 Code of Federal Regulations (CFR) § 17.38) mandates that VHA provide HPC services to eligible veterans who need these services. HPC are covered services, on equal priority with any other medical care service as authorized in the Medical Benefits Package. HPC services are to be appropriately provided in any inpatient, outpatient, or home care setting.

b. Data integrity is a critical component in the Department of Veterans Affairs (VA) health care system, as data is used for reimbursement, funding allocation, workload capture, research, and strategic planning. Accurate workload capture is an important element of resource procurement and allocation. In order to match services with needs, to prepare to meet changing needs, to monitor the adequacy of provision of these services, and to comply with Public Law 106-117, VHA needs accurate workload information on HPC in all settings. Accurate workload information raises the visibility of the magnitude of palliative care being provided or purchased. All HPC that is provided or purchased by VHA is to be depicted by the use of a specific International Classification of Diseases 9th Edition, Clinical Modification (ICD-9-CM) code including the current ICD-9-CM "V" code defined as hospice or palliative care as secondary code in all encounters. **NOTE:** Please refer to the Coding Attachment A for the ICD-9-CM code valid for the current FY.

c. HPC that is purchased by VHA is to be depicted by the entry of the appropriate Purpose of Visit (POV) codes into the Fee Application within Veterans Health Information System Technology and Architecture (VistA) and the Event Capture System of workload capture is to be used for community-based VA-purchased or VA-referred services for HPC. Additionally, the appropriate Decision Support System (DSS) identifier is used for outpatient and inpatient encounters. The DSS Event Capture System National Data Extract can be found at: <http://vaww.dss.med.va.gov/DSS%20Documents/Tech%20Guides/FY06%20NDE%20Technical%20Guide.doc> . This is an internal VA link not available to the public (see Att. A for specific coding requirements).

d. A co-payment may be charged for extended care services to 0 percent non-compensable service connected veterans and non-service connected veterans not meeting specific exemption

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criteria. Veterans in the terminal phase of illness receiving hospice care in a nursing home setting are exempt from the extended care co-payment. In order to distinguish end-of-life care that is exempt from extended care co-payment, specific hospice criteria are applied to such care in nursing home settings and must be denoted using the extended care hospice treating specialty code for VA Community Living Centers or the hospice POV code in the Community Nursing Home (see Att. A for specific coding requirements).

e. **Definitions.** To facilitate appropriate delivery of services, consistent workload capture, and adherence to co-payment policy, these service definitions must be used:

(1) **Hospice and Palliative Care (HPC).** HPC collectively represent a continuum of comfort-oriented and supportive services provided in the home, community, outpatient, or inpatient settings for persons with advanced life-limiting disease.

(a) HPC add focus on quality of life and comfort to the treatment plan in a person with advanced disease that is life-limiting and refractory to disease-modifying treatment. HPC support a balance of comfort measures and curative interventions to achieve the goals of care, as well as support and provide bereavement care to the veteran's family.

(b) Hospice is a mode of palliative care, often associated with specific characteristics of the individual receiving the care: diagnosed with a known terminal condition with a prognosis less than 6 months and desiring therapies with a palliative intent for the terminal condition.

(c) Palliative care is a broader term that includes hospice care, as well as other care that emphasizes symptom control, but does not necessarily require the presence of an imminently terminal condition or a time-limited prognosis. Palliative care may include a balance of comfort measures and curative interventions that varies across a wide spectrum.

(d) The goal of HPC is to achieve the best possible quality of life through relief of suffering, control of symptoms, and restoration of functional capacity while remaining sensitive to personal, cultural, and religious values, beliefs, and practices. Programs emphasize the comprehensive management of the physical, psychological, emotional, social and spiritual needs of the patient.

(2) **Hospice Care**

(a) The VHA definition of "hospice" care as differentiated from "palliative" care is all care provided to veterans meeting these four criteria:

1. Diagnosed with a life-limiting illness;

2. Treatment goals focus on comfort rather than cure;

3. Life expectancy is determined by a VA physician to be 6 months or less if the disease runs its normal course, consistent with the prognosis component of the Medicare hospice criteria; and

4. Accepts hospice care.

(b) The term “hospice,” as differentiated from “palliative” care, is used within VHA to denote care in the terminal phase of illness to a veteran meeting these four criteria. Hospice care meeting the four criteria, provided in the nursing home setting, is exempt from the extended care co-payment.

NOTE: Recognizing that prognosis cannot be predicted with certainty, physicians are advised to use the National Hospice and Palliative Care Organization’s Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases, Second Edition” (see Att. B for synopsis). While these prognostic guidelines are useful in determining eligibility for the Medicare hospice benefit, they are to be used as a guide, not a rigid requirement. Some patients appropriate for hospice care will survive longer than 6 months. Periodic reevaluation of patients, their prognoses, and their expected benefit from hospice care needs to be documented in the care plan.

(3) **Palliative Care Consult.** Palliative Care Consults are requests by physicians and other health care professionals to the Palliative Care Program for assistance in treating patients who have a life-limiting or serious illness and their families. Consult requests can be for either inpatient or outpatient settings and may include, but are not limited to, performing assessments and making recommendations related to prognosis, pain and symptom management, goals of care and associated treatment decisions, advance care planning, psychosocial, spiritual and other issues, family meetings, and referrals to hospice and other VA and community services. One or more members of the palliative care consult team may respond to a consult and involve other team members as indicated by the nature of the consult and needs of the patient and family.

(4) **Event Capture System.** The Event Capture System (ECS) is a generic VHA transaction data collection system, which automatically feeds facility patient care data to the DSS derived data system for national VHA cost and decision support. It is a means for capturing work performed and is representative of the care that is provided to veterans. ECS is used to capture HPC Workload for community-based VA-purchased or VA-referred services for HPC.

(5) **Encounter.** An encounter is a professional contact between a patient and a practitioner vested with primary responsibility for diagnosing, evaluating, and treating the patient’s condition. Encounters may be used to capture palliative care consultations occurring in the outpatient and inpatient settings.

3. POLICY. It is VHA policy that each VA Medical Center Director is responsible for ensuring that the proper ICD-9-CM, POV, Event Capture, and treating specialty codes are used for HPC and that outpatient encounters are recorded by the DSS identifier. *NOTE: Documentation of inpatient HPC encounters although not required by this Directive may be recorded by the DSS identifier to improve facility workload measurement.*

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4. ACTION: Each VA Medical Center Director, or designee, is responsible for:

a. Reviewing facility HPC services to ensure that clinical providers denote “Palliative Care” in the medical record whenever palliative care is the primary goal of care, and denote “Hospice Care” when consistent with the VHA definition.

b. Ensuring that such care is coded using the current ICD-9-CM as a secondary diagnosis for all HPC services and that POV, Event Capture, DSS identifier, and specific treating specialty codes as detailed in Attachment A, are accurately and appropriately used. *NOTE: Medical prognostic guidelines are identified in Attachment B, and if further information is needed, through the Office of Geriatrics and Extended Care (114), VA Central Office at 202-461-6750.*

c. Ensuring that the following mandated coding guidelines are used:

(1) **Coding for Hospice and Palliative Care Provided by VHA Staff.** HPC provided by VHA staff to veterans in a VA facility, VA clinic, or in the home of the veteran must be clearly distinguished as “Hospice” or “Palliative Care” in a consult, admission note, progress note, or physician extender orders. Bereavement services are an integral component of hospice care, and need to be similarly noted. Specific ICD-9-CM coding guidelines must be followed, and HPC is to be coded with the secondary ICD-9-CM code currently valid. A separate primary diagnosis must also be noted and recorded.

(a) For example, a veteran with advanced dementia may be receiving outpatient HPC consistent with the expressed primary goal of comfort, and then develop a hip fracture from a fall. Surgical repair of the hip fracture may be appropriate, with the goals of reducing pain and promoting maximal mobility. The principal diagnosis code needs to reflect the hip fracture and those providing the treatment. If the admission orders or admission note indicate “Hospice” or “Palliative Care” then a secondary ICD-9-CM code currently valid and defined for this service is to be included.

(b) In another situation, if a veteran has been receiving curative care in one VA setting, and an additional goal of care is added to include comfort care, any transfer to another service is to have “Palliative Care” noted in the admission orders or admission note by the receiving care team. Medical record documentation requirements must be followed to substantiate the type of care provided, and the current ICD-9-CM code for these services is included as the secondary diagnosis for subsequent encounters.

(c) Many veterans cared for by Home Based Primary Care (HBPC) have serious chronic illness that is refractory to medical therapy and desire palliative care goals of comfort concurrent to their usual care, while not being ready for hospice enrollment. Typical diagnoses of these HBPC patients include, but are not limited to Chronic Obstructive Pulmonary Diseases (COPD), Congestive Heart Failure (CHF), and dementia. In such cases, the palliative care ICD-9-CM code, entered as a secondary diagnosis should be selected in encounters dealing with advanced life-limiting chronic illness. A physician, physician extender, or psychologist initially documents the provision of palliative care in a consult, admission note, progress note, or in physician or physician extender orders. The provider selects the palliative care ICD-9-CM

secondary code as a new code to populate the problem list. All disciplines then document the provision of palliative care as indicated.

(2) **Coding for Hospice Care Provided in a Nursing Home.** Hospice care provided in a nursing home setting to veterans in the terminal phase of illness is exempt from the extended care co-payment. Veterans meeting the VHA definition for hospice care who receive this care in a VA Community Living Center setting must be assigned the Extended Care Hospice Treating Specialty Code 96. Veterans meeting the VHA definition for hospice care who receive hospice care in a VA-paid community nursing home bed through the Community Nursing Home (CNH) program must be assigned Fee POV code 43. The CNH Hospice POV code 43 must be used for every VA-paid episode of CNH care meeting the VHA definition of hospice care, as this care is exempt from extended care co-payment. Additionally, the appropriate ICD-9-CM codes must also be used, including the secondary code for HPC workload capture

(3) **Coding for VA Purchased Community-based Hospice and Palliative Care.** All episodes of HPC that are purchased by VHA and provided in a non-VA setting are required to be entered into the Fee Application within VistA and denoted with POV codes 77 or 78 through the Fee Package. These purchased services must meet the VHA definition of “hospice and palliative care.” Standard co-payment policy applies. The appropriate ICD-9-CM codes must also be used, including the secondary code for HPC workload capture (see Att. A for the use of POV and Event Capture codes for hospice and palliative care).

(4) **Coding in Event Capture for purchased or non-VA paid referred Home and Community-based Hospice and Palliative Care.** The appropriate code must be entered into the Event Capture workload system for VA paid and non-VA paid referred home and community based HPC services.

(5) **Hospice and Palliative Care Outpatient and Inpatient Encounters.** DSS Identifier 351 records patient encounters for improved care at end-of-life in both outpatient and inpatient settings. Care is provided to patients through a coordinated, interdisciplinary provision of medical, nursing, and psychosocial services. Hospice and Palliative Care provides education, counseling, advocacy, care coordination to patients and caregivers, referral for specialty or other levels of care, follow-up, and overall care management in order to improve the individual’s quality of life for those who are at the advanced or end stage of illness. The care includes both clinical and administrative services. Although the DSS identifier 351 captures all encounters that are performed under a hospice or palliative care clinic, clinical documentation is essential to ensure appropriate coding of the encounter as outlined in Attachment A under Coding guidelines for an inpatient and outpatient encounter. It is important for the level of complexity of the encounter to be documented to ensure accurate measurement of workload.

d. Ensuring that proper DSS and Monthly Program Cost Report (MPCR) accounts support the preceding codes.

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5. REFERENCES

a. American Hospital Association Coding Clinic, First Quarter, 2005

b. Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases, Second Edition, The National Hospice Organization, 1996.

6. FOLLOW-UP RESPONSIBILITY: The Office of Patient Care Services (114) is responsible for the contents of this Directive. Questions should be addressed to 202-461-6750.

7. RESCISSIONS: VHA Directive 2002-038, Hospice and Palliative Care Workload capture dated July 5, 2002, is rescinded. This VHA Directive expires August 31, 2013.

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ATTACHMENT A

HOSPICE AND PALLIATIVE CARE: CODING RULES

1. Definition. Hospice and palliative care (HPC) collectively represent a continuum of comfort-oriented and supportive services provided in the home, community, outpatient, or inpatient settings for persons with advanced life-limiting disease. HPC adds focus on quality of life and comfort to the treatment plan in a person with advanced disease that is life-limiting and refractory to disease-modifying treatment. HPC supports a balance of comfort measures and curative interventions to achieve the goals of care, as well as support and provide bereavement care to the veteran's family.

a. For Veterans Health Administration (VHA) workload capture, HPC services are treated as a single spectrum of care and assigned International Classification of Diseases 9th Edition, Clinical Modification (ICD-9-CM) code V66.7.

b. For discernment of extended care co-payment, "hospice" is defined in VHA as all care provided to veterans meeting four criteria:

(1) Diagnosed with a life-limiting illness;

(2) Treatment goals focus on comfort rather than cure;

(3) Life expectancy is determined by a Department of Veterans Affairs (VA) physician to be 6 months or less, if the disease runs its normal course, consistent with the prognosis component of the Medicare hospice criteria; and

(4) Accepts hospice care.

2. Coding for Workload Capture. All HPC that is provided or purchased by VHA is to be depicted by the use of ICD-9-CM secondary code V66.7. This ICD-9-CM code V66.7 is to be used for HPC in any inpatient, outpatient, or home care setting. Code V66.7 is a secondary diagnosis code and must be accompanied by a primary diagnosis code.

3. Coding in Addition to HPC Workload Capture. Other coding in addition to ICD-9-CM V66.7 must be applied specific to the circumstance, as described in following paragraphs.

4. Coding Instructions for Care Provided by VA Staff. The coding of HPC that is provided directly by VA staff, whether in an inpatient facility, an outpatient clinic, the home of a veteran, or other setting, must follow these instructions:

a. **Inpatient Care.** The secondary diagnosis will indicate HPC, using ICD-9-CM code V66.7 for all care meeting the VHA definition of HPC. A separate principal diagnosis code must be included. The principal diagnosis is the condition, after study, that is determined to be the reason for admission. Treatment of the principal diagnosis may involve hospice or palliative care, but HPC cannot be listed as the principal diagnosis. An example follows:

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Question: A patient is admitted with end-stage lung cancer, for palliative care only. How should this be coded?

Answer: Assign principal diagnosis code 162.9, Malignant neoplasm of bronchus and lung, unspecified, and secondary code V66.7, Encounter for palliative care (see American Hospital Association (AHA) Coding Clinic, First Quarter, 2005).

b. **VA Community Living Center.** The Treating Specialty code 96 for hospice care in a VA extended care inpatient setting must be used when a veteran is admitted to a VA Community Living Center bed for hospice care and meets all four VHA hospice care criteria.

c. **Outpatient Care.** If the primary goal of care meets the HPC definition, then HPC ICD-9-CM code V66.7 needs to be listed as a secondary diagnosis code. In addition, a separate primary diagnosis code must be included. The primary diagnosis is the primary reason for the encounter, i.e., congestive heart failure, whereas the hospice or palliative care code of V66.7 is secondary. *NOTE. Documentation of encounters and the Hospice Decision Support Systems (DSS) identifier 351 does not differentiate the complexity of the provided encounter. A palliative care consultation is a complex encounter and needs to be at least a level III encounter (i.e., have a history, review of systems, full physical exam, and a plan that addresses at least three areas of interest).*

5. Coding Instructions for Non-VA Care, Paid for by VA

a. For non-VA care that is purchased by VA, processing authorizations and payment of invoices for HPC require the use of the Veterans Health Information System Technology and Architecture (VistA) Fee Basis Application. User instructions can be found in the Fee Basis User Manual and Fee Basis Guidebook, through the Austin Automation, Fee Web site at <http://vaww.aac.va.gov/fee>. This is an internal VA link not available to the public.

b. The Fee Basis Patch and descriptions for Purpose of Visit (POV) codes 43, 77, and 78 follow. Community Nursing Home (CNH) Hospice POV code 43 is to be used when the veteran meets all four VHA hospice care criteria, and agrees to receive hospice care through the Community Nursing Home Program. Outpatient HPC POV codes 77 and 78 are to be used for care that meets the VHA HPC definition.

(1) Fee Basis POV codes 43, 77, and 78

43	Inpatient	CNH Hospice
77	Outpatient	Hospice and Palliative Care Out Patient Treatment (OPT)- Contractor Sharing Agreement (renamed)
78	Outpatient	Hospice and Palliative Care (OPT) - (Title 38 Code of Federal Regulations)

6. Coding instructions of Event Capture System for capturing VA-paid or VA referred Home and Community-based HPC service. The Event Capture System of workload capture is used for HPC care that is purchased or referred by the VHA. Codes and definitions are included in table one.

Table One

<u>Fdr Sys</u>	<u>IP Num</u>	<u>FdrKey</u>	<u>Short Description</u>	<u>When to Use the Code</u>
ECS	50899	HH038	HH REFER VA PURCH HOSPICE	Enter this code for the Start Date of purchased Hospice services when care is provided in a setting <u>not</u> in the home and VA is paying for the service; i.e., care is provided in a Community Nursing Home or other inpatient setting.
ECS	50900	HH039	HH END VA PURCH HOSPICE	Enter this code for the Stop Date of purchased Hospice services when the care is provided in a setting <u>not</u> in the home and VA is paying for the services.
ECS	50914	HH053	HH REFER TO VA PD HM HSPC	Enter this code for the Start Date of purchased Hospice services provided <u>in the home</u> when VA is paying for the services
ECS	50915	HH054	HH REF TO END VA PD HHSPC	Enter this code for the Stop Date of purchased Hospice services provided <u>in the home</u> when VA is paying for the services
ECS	50920	HH059	HH REF HOME HOSPICE MEDCR	Enter this code when a referral is generated for Home Hospice care and <u>Medicare</u> is the pay source. Use the date the referral is made (either by phone call or mailing of paper work)
ECS	50921	HH060	HH REF HOME HOSPICE MEDCD	Enter this code when a referral is generated for Home Hospice care and <u>Medicaid</u> is the pay source. Use the date the referral is made (either by phone call or mailing of paperwork).
ECS	50922	HH061	HH REF HOME HOSP THRD PTY	Enter this code when a referral is generated for Home Hospice care and <u>third-party reimbursement</u> is the pay source. Use the date the referral is made (either by phone call or mailing of paperwork).
ECS	50937	HH076	HH REFER TO VA PURCH PALLIATIVE CARE	Enter this code for the Start Date for palliative care (<u>not</u> hospice) that is provided in the home and the pay source is VA.
ECS	50938	HH077	HH END VA PURCH PALLIATIVE CARE	Enter this code for the Stop Date for palliative care (<u>not</u> hospice) that is provided in the home and the pay source is VA.

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<u>Fdr Sys</u>	<u>IP Num</u>	<u>FdrKey</u>	<u>Short Description</u>	<u>When to Use the Code</u>
ECS	50942	HH094	HH PURCH VISITS/MO HOSPCE	This code is entered for each day of care authorized by VA for community hospice services <u>not</u> in the home during a given month at VA expense
ECS	50949	HH101	HH PURCH VISITS/MO HMHSPC	This code is entered for each day of care authorized by VA for hospice services <u>in the home</u> during a given month at VA expense.
ECS	50954	HH106	HOSPICE PURCH VISITS/MO PALLATIVE CARE	This code is entered for each day of care authorized by VA for palliative (<u>not</u> hospice) services <u>in the home</u> during a given month at VA expense.

7. Coding instruction for the complexity level of outpatient and inpatient encounters to be used with DSS identifier 351. *NOTE: These coding guidelines apply to physician or physician extender encounters.* In the palliative care setting all initial encounters and a lot of subsequent encounters are complex (Level III or above) as they answer to multiple elements of patient care, education, caregiver support, etc. The appropriate documentation is vital in capturing this workload and is based on the following elements or definitions:

a. **History and Exam are:**

- (1) **PF** = Problem Focused
- (2) **E** = Expanded
- (3) **D** = Detailed
- (4) **C** = Comprehensive

b. **Medical Decision-Making is:**

- (1) **S** = Straight forward
- (2) **LC** = Low Complexity
- (3) **MC** = Mod Complexity
- (4) **HC** = High Complexity

c. **New Patient.** A new patient is one who has not received any professional services from the physician or another member of the same specialty group in the last 3 years.

d. **Established Patient.** An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

e. **The Complexity of Medical Decision-Making**

(1) **It is dependent upon:**

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- (a) The number of diagnoses or management options.
- (b) The amount or complexity of data to be reviewed, and
- (c) The risk of complications or morbidity or mortality.

(2) History, exam, and medical decision making are considered the key components that must be performed when selecting a visit code.

(a) Perform all three components for new outpatient visits, initial consults (inpatient or outpatient), initial hospital care, and Emergency Department.

(b) Perform two components for follow-up consults, established outpatient visits, and subsequent hospital care.

(c) Time becomes a key factor in selecting a level of service only when counseling or coordinating care accounts for over 50 percent of the time spent with the patient.

f. **New Outpatient Visit**

Level	Visit Code	History and Exam	Decision making
Level I	99201	PF	S
Level II	99202	E	S
Level III	99203	D	LC
Level IV	99204	C	MC
Level V	99205	C	HC

g. **Established Outpatient Visit**

Level	Visit Code	History and Exam	Decision making
Level I	99211		
Level II	99212	PF	S
Level III	99213	E	LC
Level IV	99214	D	MC
Level V	99215	C	HC

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h. Outpatient Consult (New or Established)

Level	Visit Code	History and Exam	Decision making
Level I	99241	PF	S
Level II	99242	E	S
Level III	99243	D	LC
Level IV	99244	C	MC
Level V	99245	C	HC

i. Inpatient Consult (Initial)

Level	Visit Code	History and Exam	Decision making
Level I	99251	PF	S
Level II	99252	E	S
Level III	99253	D	LC
Level IV	99254	C	MC
Level V	99255	C	HC

j. Inpatient Consult (Follow-up)

Level	Visit Code	History and Exam	Decision making
Level II	99261	PF	S-LC
Level III	99262	E	MC
Level IV	99263	D	HC

ATTACHMENT B

ESTIMATING PROGNOSIS IN NON-CANCER DISEASES

NOTE: Adapted from Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases, 2nd Ed., National Hospice Organization, Arlington VA, 1996.

The following are guidelines; fulfilling the criteria for any of the categories supports that a patient has a prognosis less than 6 months, and may be deemed appropriate for hospice care and referral for the Medicare hospice benefit. *NOTE: Other criteria may apply.*

1. General. The patient meets all the following:

a. Life-limiting condition;

b. Treatment goals are for comfort rather than cure;

c. In the past 6 months, the patient has either documented terminal disease-related decline in nutritional status (weight loss more than (>)10 percent) or clinical progression of disease (repeated emergency room or inpatient admissions, or functional status decline).

2. Congestive Heart Failure. The patient meets, on optimal treatment:

a. Class IV heart failure or ejection fraction less than (<) 20 percent; and

b. Syncope, cardiac arrest, cardiogenic stroke, or symptomatic arrhythmia.

3. Chronic Obstructive Pulmonary Disease. The patient meets some of the following:

a. Dyspnea at rest unresponsive to bronchodilators. Forced Expiratory Volume (FEV1) after bronchodilator < 30 percent of predicted.

b. Dyspnea limits walking to a few steps.

c. Resting pCO₂ > 50; O₂ Saturation < 88 percent or pO₂ < 55 on supplemental oxygen; Cor pulmonale.

d. Weight loss > 10 percent of body weight; resting tachycardia > 100.

4. Renal Failure. Chronic renal failure with creatinine > 8.0 mg/dL, off dialysis.

5. Cirrhosis or Liver Failure. With clinical judgment, the patient:

a. Spends most time in bed, INR > 1.5, albumin < 2.5 g/dL.

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b. Evidences comorbidity: encephalopathy, spontaneous bacterial peritonitis, refractory ascites, recurrent variceal bleeding, hepatorenal syndrome, or wasting.

6. **Dementia.** The patient meets all the following:

- a. Speech limited to six words;
- b. Bed-bound;
- c. Incontinent;
- d. Unable to ambulate, dress, and bathe without assistance; and

e. A comorbidity in prior year; i.e., pyelonephritis, pressure ulcer, sepsis, fever after antibiotics, difficulty feeding with aspiration pneumonia or weight loss > 10 percent.

7. **Human Immunodeficiency Virus (HIV) Disease.** The following have been correlated with early mortality, but given recent advancements in therapies for HIV, the provider and HIV patient need to agree that Hospice care would benefit the patient at the current stage of illness:

- a. CD4+ count below 25 cells/ μ L;
- b. Viral load > 100,000/ml;
- c. Declining functional status;
- d. Certain opportunistic infections;
- e. Albumin < 2.5 g/dL.

8. **Strokes or Coma**

a. **Acute Phase.** The patient meets any of the following:

- (1) Coma or persistent vegetative state 3 days after stroke.
- (2) Any four of the following on day three of the coma:
 - (a) No verbal response.
 - (b) Abnormal brain stem response.
 - (c) No response to pain.
 - (d) Serum creatinine > 1.5 mg/dL, Age > 70.

(e) Dysphagia preventing adequate intake in a patient who is not a candidate for artificial nutrition.

b. **Chronic Phase.** The patient meets some of the following:

(1) Poor functional status;

(2) Dementia dependent in ambulation, dressing, bathing and toileting;

(3) Weight loss > 10 percent, albumin < 2.5g/dL.

(4) Complications to include: aspiration pneumonia, pyelonephritis, sepsis, stage three or four decubitus, or fever after antibiotic.

9. Amvotrophic Lateral Sclerosis (ALS). The patient evidences a rapid progression of ALS, with decline in one of the following:

a. Ventilatory capacity,

b. Swallowing, or

c. Functional status.